

## Health, Allergy & Medication Questionnaire

**medcohealth**  
*live life well*

Your answers to the following questions will help us provide your pharmacy benefit services including, for example, filling prescriptions and alerting your doctor about possible medication problems. To best serve you, we need to know if you have any known allergies, conditions or diseases. Please complete the questionnaire and return with your prescription for Medco Health Home Delivery Pharmacy Service.™

## Section 1: Member Identification and Contact

**Group Number** → **MAA 2507850**

**Print your patient identification code in boxes below.**

**Daytime Telephone Number**[illegible]

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**Please Print First name**

**M.I. Please Print Last Name**

MM	DD	YYYY
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DD		
<b>Date of Birth</b>		

**Street Address/Apt No.**

<b>Gender</b>	<b>Male</b>	<b>O</b>
	<b>Female</b>	<b>O</b>

City

State

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**Zip**

**Section 2: Drug Allergy Conditions** Please fill in the circle **ONLY** if you have an allergy or had a bad reaction happened anytime in the past. Correct way to mark circles: ● *Please use blue or black ink.*

Penicillin/Cephalosporin Antibiotics (e.g. ampicillin, Keflex®)	<b>O</b>	Tetracycline Antibiotics	<b>O</b>	Erythromycin, Biaxin®, Zithromax®	<b>O</b>	Codeine (e.g Tylenol #3)	<b>O</b>
Non-steroidal anti-inflammatory (NSAID) drugs (e.g. Ibuprofen)	<b>O</b>	Aspirin (e.g. Salicylates)	<b>O</b>	Sulfa drugs	<b>O</b>	Iodine	<b>O</b>

*If your allergy is not listed, please print the name of the medication allergy here . Example: Morphine*

**Section 3: Medical Conditions** Please fill in a circle **ONLY** if a doctor ever said you have any of the following conditions.

Heart Failure (weak heart)	<b>O</b>	Gastric reflux, heartburn or esophagitis( <b>GERD</b> )	<b>O</b>
High blood pressure ( <b>hypertension</b> )	<b>O</b>	Inflammatory bowel disease ( <b>colitis, Crohn's disease</b> )	<b>O</b>
Heart attack or angina	<b>O</b>	High pressure in the eyes ( <b>glaucoma</b> )	<b>O</b>
High cholesterol ( <b>hypercholesterolemia</b> )	<b>O</b>	Seizures	<b>O</b>
Stroke	<b>O</b>	Poor circulation in the legs (peripheral vascular disease)	<b>O</b>
Chronic bronchitis or emphysema ( <b>COPD</b> )	<b>O</b>	Trouble with blood not clotting properly	<b>O</b>
Asthma	<b>O</b>	Enlarged prostate (benign prostatic hyperplasia, <b>BPH</b> )	<b>O</b>
Allergies, runny nose, hay fever ( <b>allergic rhinitis</b> )	<b>O</b>	Arthritis	<b>O</b>
High blood sugar ( <b>diabetes</b> )	<b>O</b>	Osteoporosis	<b>O</b>
Thyroid disease	<b>O</b>	Depression	<b>O</b>
Peptic, stomach or duodenal ulcer	<b>O</b>	Migraine headaches	<b>O</b>

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*Print other medical conditions here -Example - Glaucoma*

Information you provide may be released to and used by the plan administrator, sponsor, and/or their agents in connection with the benefit plan program. Information may be used for other reporting and analysis purposes without identification of you.

***Please return the questionnaire with your prescription or refill order form.***